CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS A MIDWIFERY PRACTITIONER
INSTRUCTION SHEET

When to File

Before you file this application, you must complete a course in pharmacology and IV therapy acceptable to the Midwifery Advisory Council.

The documentation that you are required to submit in support of your application depends in part on the type of application you are filing.

- **CPM – Certified Professional Midwife** – Select this type if you have received certification by the North American Registry of Midwives (NARM) or its equivalent or successor.
- **CM – Certified Midwife** – Select this type if you have received certification by the American Midwifery Certification Board (AMCB) or its equivalent or successor.

Requirements for *All* Applicants

Please read all instructions carefully before completing and submitting your application. If your application is not complete within 12 months of filing, it may be considered abandoned and discarded.

The following summarizes the documentation requirements for all applicants. The application form may request additional documentation based on your answers to the questions.

☐ Submit completed, signed and notarized *Application for Licensure as a Midwifery Practitioner*.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.
- Forms that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose non-refundable processing fee by check or money order made payable to "State of Delaware."
- Applications submitted without this processing fee will be rejected.

☐ If you now hold, or have *ever* held, a Midwifery Practitioner license in any jurisdiction (state, U.S. territory, District of Columbia) other than Delaware, arrange for the Council office to receive a *Verification of Midwifery Practitioner License form* from *each* jurisdiction where you have held a license.
- Before forwarding the form, check whether the jurisdiction requires a fee.
- The Council office must receive the completed verification *directly* from the other jurisdiction. The jurisdiction's seal must be affixed to the form.
- Internet or faxed verifications will not be accepted.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families following the instructions on the form.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

☐ Enclose a copy of your high school transcript or diploma, or evidence that you have completed a higher level of education.

☐ Enclose a copy of your birth certificate, passport, an identification card or driver's license issued by your state of residence showing that you are at least 21 years old.

☐ Submit certificates showing that you have completed a current Basic Life Support (BLS) course and a current Neonatal Resuscitation Program (NRP) that includes *hands-on* skills training.

☐ Submit documentation that you have completed a course in pharmacology and IV therapy acceptable to the Council.
- A course is acceptable when offered by a postsecondary educational institution accredited by a board recognized by the Council for Higher Education Accreditation of the American Council on Education ***or*** when approved by the Midwifery Education and Accreditation Council (MEAC) (Section 13.2.8 of the Council's Rules and Regulations).

Additional Requirement for CPM Applicants

☐ Arrange for the Council office to receive verification that you have a valid CPM credential from North American Registry of Midwives (NARM) or its equivalent or successor. Verification must be sent *directly* from the organization to the Council office.

Additional Requirement for CM Applicants

☐ Arrange for the Council office to receive verification that you have a valid CM credential from American Midwifery Certification Board (AMCB) or its equivalent or successor. Verification must be sent *directly* from the organization to the Council office.

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APPLICATION FOR LICENSURE AS A MIDWIFERY PRACTITIONER

TYPE OF APPLICATION

1. Select the type of application you are choosing to file (check one):

   ☐ CPM – Certified Professional Midwife – I currently hold certification by the North American Registry of Midwives (NARM) or its equivalent or successor.

   ☐ CM – Certified Midwife - I currently hold certification by the American Midwifery Certification Board (AMCB) or its equivalent or successor.

IDENTIFYING AND CONTACT INFORMATION

2. Full Name: _____ _____ _____
   Last First Middle

3. Other Names Used: _____ _____ _____
   Include maiden, former married, alternate spellings.

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

   Enclose a copy of your birth certificate, passport, an identification card or driver's license issued by your state of residence showing that you are at least 21 years old.

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:** _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement.*

6. Address: _____

   _____ _____ _____
   City State Zip

7. Telephone: _____ _____ Email: _____ None ☐
   daytime or cell fax

EDUCATION & CERTIFICATION INFORMATION

8. Are you a high school graduate or equivalent? Yes ☐ No ☐

   Enclose a copy of your high school transcript or diploma, or evidence that you have completed a higher level of education.

9. Check the type of certification you *currently hold:*

   ☐ North American Registry of Midwives (NARM)

   ☐ American Midwifery Certification Board (AMCB)

   Arrange for the Council office to receive verification of your certification *directly* from the organization.

10. Have you completed a current Basic Life Support (BLS) course and a current Neonatal Resuscitation Program (NRP) that includes *hands-on* skills training? Yes ☐ No ☐

    Submit certificates showing that you have completed the required training.

11. Have you completed a course in pharmacology and IV therapy? Yes ☐ No ☐

    Submit documentation you have completed the course.

INFORMATION ABOUT LICENSURE & PRACTICE

12. Are any disciplinary actions or complaints pending against you before any body that regulates the practice of midwifery? Yes ☐ No ☐ **If yes, on a separate sheet, identify where the action is pending, describe the complaint/action, and include the anticipated date of resolution, if known. Enclose the sheet with the application.**

13. Have you ever had a midwife practitioner license denied, revoked, suspended or limited or placed on probation? Yes ☐ No ☐ **If yes, explain on a separate sheet and enclose with this application. Also, enclose a copy of the disciplinary order**.

14. Do you now hold, or have you ever held, a license to practice as a midwife practitioner in any jurisdiction (state, District of Columbia, or U.S. territory)? Yes ☐ No ☐ If yes, enter information about your licenses:

JURISDICTION	LICENSE NUMBER	EXPIRATION DATE

Arrange for a *Verification of Midwife Practitioner License* form to be sent to the Council office *directly* from *each* jurisdiction where you have ever held a midwifery practitioner license.

HEALTH AND DISABILITY

15. Within the two years preceding this application, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a midwife practitioner, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐
    - **If yes, explain on a separate sheet and enclose with this application.** Continue with the next question.
    - If no, skip to the **DISCLOSURES** section.

16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐ **If yes, explain on a separate sheet and enclose with this application.**

DISCLOSURES

17. Have you ever been disciplined by a healthcare facility or any entity governing midwifery licensure? Yes ☐ No ☐ **If yes, explain on a separate sheet and enclose it with this application. Also, enclose a copy of the disciplinary action.**

18. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐ **If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue with the next question.** If no, skip to the **DUTY TO REPORT** section.

19. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐

DUTY TO REPORT

20. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

21. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to self report all of the following:
    - Any change in hospital allied healthcare privileges and any disciplinary action taken by any medical society against you within 30 days (24 *Del. C.* §1730(b)(1))
    - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 *Del. C.* §1730(b)(2))
    - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 *Del. C.* §1730 (c))
    - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 *Del. C.* §1731A (f))
    - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 *Del. C.* §1730 (d))
    - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 *Del. C.* §1730 (d))

    I certify that I have read and understand all of provisions in the Delaware Medical Practice Act, including those listed above, and understand my *duty to self report*. Yes ☐ No ☐

    Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families following the instructions on the form.

    To ensure consideration of your license application at the next Council meeting, the Division must receive all of these items no later than 4:30 PM ten full working days before the Council's meeting date:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I further understand that by filing this application for a Midwife Practitioner in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Board of Medical Licensure and Discipline and Council's Rules and Regulations and to determine that I am physically and mentally capable of engaging in the practice of midwifery with safety to the public.

I authorize the Midwifery Advisory Council of the Board of Medical Licensure and Discipline and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Board of Medical Licensure and Discipline any such information, including document, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to permit the Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Midwifery Advisory Council of the Delaware Board of Medical Licensure and Discipline will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to

- Keep the information in this application current until such time as the Board has finally acted on it, and
- Promptly provide any and all additional information requested by or on behalf of the Board.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order **(*personal checks are not accepted*)** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Revised 2/2017

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 2/2017

DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM

Fax or Mail Request to:

OCCL, Criminal History Unit
Concord Plaza, Hagley Building
3411 Silverside Road
Wilmington, DE 19810
Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed.**
- **Do not use a cover sheet.**
- **Do not send duplicate requests.**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed.**

PART I. APPLICANT INFORMATION – Type or print clearly.

Name: _____ _____ _____
Last First Middle

Other Name(s) Used: _____ _____ _____ DE Drivers License #: _____

Social Security #: _____ - ___ - _____ Date of Birth: ___ / ___ /_____ Sex: Male ☐ Female: ☐ Race: _____
mm / dd / yyyy

Address: _____ _____ _____ _____
Street City State Zip

Have you ever been involved in a substantiated case of child abuse or neglect? Yes ☐ No ☐ If Yes, explain:

_____

_____

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: _____ Date:_____

Parent or Guardian Signature if applicant is under the age of 18: _____

PART II. AGENCY/ORGANIZATION INFORMATION

Please check only one:

☐ EDUCATION ☐ HEALTH CARE FACILITY ☐ CHILD CARE ☒ OTHER: State Agency

Agency Identification Number (if applicable): 1179
Requesting Agency Name: **Division of Professional Regulation**
Address: Cannon Building, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904
Phone: (302) 744-4500 Fax: (302) 739-2711 Contact Person: Nicole Williams

DSCYF USE ONLY

The individual listed above (___ is listed) (___ is NOT listed) on the Delaware Child Protection Registry.

Date: _____ DSCYF Criminal History Unit _____

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VERIFICATION OF MIDWIFE PRACTITIONER LICENSE

Send a form to *each* jurisdiction (other than Delaware) where you have ever held a license to practice as a Midwife Practitioner.

Licensing Authority:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Date of Birth:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ I am applying for licensure as a Midwife Practitioner in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Midwifery Advisory Council. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/U.S. Territory of _____ License Number: _____ Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, please enclose a certified copy of the Board Order with this license verification.**
CERTIFICATION AFFIX OFFICIAL SEAL HERE	**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**